

**SUMMARY PAPER:
COMMUNITY CARE SYSTEM FOR THE ELDERLY
IN MANITOBA, CANADA**

prepared by

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March 7, 1992

**Summary Paper prepared for presentation of
Community Care System for the Elderly in Manitoba, Canada
A paper presented at the
International Symposium on Social Care for the Elderly:
Community Care Systems in the Human Services
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The community care system for the elderly in Manitoba, Canada is the Home Care Program. It was developed in 1974 by the Provincial Government of Canada. This paper provides detailed information describing all aspects of the Program. It provides statistical information on the elderly in Canada and specifically in Manitoba. There is a full description of the Home Care Program including: information on central program office administration, decentralized service delivery systems, specialty programs, management and financial information systems, referral system, eligibility criteria assessment, care planning and case coordinator functions. Discussion of the field delivery aspects of the Program are emphasized, including the organization of services and case coordination and case management at the field level describing how an individual is "cared for" in the community. Factors impacting on the Home Care Program development and issues facing community based long and short term programs are included. There is a section discussing the results of the Home Care Program on the health care delivery system in Manitoba. Diagrams and documents are included which describe process of program management and delivery and includes statistical data from the Office of Home Care.

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Introduction

Seniors constitute one of the fastest growing groups in Canada. They represented approximately 12% of the Canadian population in 1991. Canada is facing an increasing aging population with particular growth being more pronounced among those 75 years of age and over. This is highlighting a concern that the large and increasing number of seniors will strain the existing system for the provision of medical, social and other services. All of the provinces in Canada have community based care programs for the elderly. The impact of an aging elderly segment of the population as a whole is being addressed across Canada at this time. Diagram 1 provides information on the elderly population in Canada.

The Federal Government (Canadian Government) has a primary responsibility for cost sharing of identified health care expenditures at the Provincial level. Federal criteria have been established for the Province to meet in order to qualify for these cost sharing programs. Cost sharable expenditures include the following:

1. Hospital services and construction;
2. Physician services;
3. Long term care facilities, services and construction;
4. Community-based care services.

The trend at the Federal Government level today is to divest itself of responsibility for cost-sharing in health care and to move toward the provision of consultative services. The impact of Federal withdrawal of funds has had serious implications for planning of health care in the Province of Manitoba.

The responsibility for the delivery of health care is constitutionally vested in the Provincial Government. Diagram 2 shows the structure of the Government of the Province of Manitoba. Diagram 3 shows the organization and structure of the Ministry of Health for the Province of Manitoba. The Ministry is currently being reorganized to bring institutional and community sector planning together in order to facilitate cost effective

and cost efficient health services delivery. The Home Care Program is within the Ministry of Health in the Continuing Care Programs Division as noted in Diagram 3.

Manitoba's Home Care Program

Background:

Manitoba was the first province in Canada to take the formal initiative of recognizing the needs of the elderly and the need to plan for the aging of its population. The Manitoba Longitudinal Study on Aging¹ began in 1971 and continues today. Demographic projections, the "Aging in Manitoba" study and analysis of existing services and gaps led to the creation of the Manitoba Home Care Program in 1974. Diagram 4 shows Manitoba's elderly population in specific age breaks from 65 plus, over the time period 1988 to 1990 inclusive.

The Home Care Program was mandated through a Government Policy paper. It was not legislated by an "act" of Government. Initially the concept of the Program was to design a community support program that would provide a range of health and social services in order to delay or divert people from attending the higher cost health care services within the Province. It was designed as a cost containment, cost reduction program in the health care system. The Home Care Program was created to facilitate hospital discharges, to provide alternatives to entry to the Personal Care Home system, and lastly, to provide individuals with care at home who would otherwise be at risk of leaving their own home and having to enter a higher health care cost service. The philosophy, objectives, and mode of service delivery of the Program have remained constant since its inception.

The Home Care Program has two major components:

1. Home Care. This includes case identification, assessment, care planning, resource development, coordination of related components;

1 Betty Havens and Enid Thompson, Department of Health, Research and Planning

2. Assessment for personal care home placement. This includes assessment, paneling, waiting list management and prioritization for entry into personal care homes.

The Program philosophy continues to be stated as follows:

"Individuals progress toward and remain in a high state of wellness in the familiar environment of their own home. It is preferable for individuals to remain at home to the extent that needed resources can be made available. Care in a facility is appropriate where resources of person, family, community and program cannot sustain an individual in the home."²

The Organizational Structure of the Program

Central Program Administration

There is one central office called the Home Care Office which has the provincial responsibility for the central administration of this Program. The central office has the responsibility for policy, policy development, administrative structures; financial management systems, budget development and allocation, reporting, program evaluation, program monitoring, program audit, evaluation, monitoring of standards of practice and standards for program delivery.

The central office has provincial coordinating responsibility for the Home Care Program. All service delivery agencies/regions providing home care services have a program reporting line to the central office. All budget allocations for the delivery of home care are managed through the Office of Home Care. The functions of the central office are detailed on Diagram 15. Coordination of services within the Program and across programs is essential in order to develop a rational resource base assuring effective and efficient service to clients at the most reasonable cost to Government. Collaboration, liaison committees, program linkages, conjoint committees,

are all negotiated decision making processes, critical as underpinnings of a coordinated provincial program. The central coordinating office ensures the Provincial Government of an accountability centre for the expenditure of Government dollars, the development of policy and the monitoring of Program delivery and development.

Decentralized Service Delivery

The central office has designated home care coordinating agencies in order to ensure effective service delivery to all areas of the Province of Manitoba. The coordinating agencies have the responsibility for the provision of Home Care in accordance with the Home Care Policy and Program Guidelines. The coordinating agencies are assigned budget allocations. They are responsible for program reporting to the central office. They are responsible for determining eligibility for Home Care and determining care plans for their clients on the Home Care Program. All standards and policies within the Provincial Home Care Program are utilized by the coordinating agencies.

The Victorian Order of Nurses (a non-profit nursing organization) operates in the City of Winnipeg only. It is responsible for coordinating all short term care in metropolitan Winnipeg (which comprises approximately 60% of Manitoba's total population). Short Term Care is designed to facilitate hospital discharges or care to terminally ill persons for 60 days or less. This is essentially a nursing service with some support home maintenance staff. The range and scope of service is relatively limited, as short term care was envisioned primarily for convalescent or terminally ill patients, and would therefore be largely dependent on nursing and home support services.

The Winnipeg Region (Government service delivery system) is the other Home Care coordinating agency in the City of Winnipeg. The Winnipeg Region has responsibility for coordination of all long term care cases. Long Term Care is defined as care required for 60 days or longer. Individuals who require Home Care for long term convalescence, and/or alternative to personal care home placement or to remain in their own home for an ongoing period would be referred to this program. The Long Term Care

Program has the broadest resource base dealing with both health and social support services in order to continue to meet need over time for the individual who is remaining in the community.

The hospitals in the City of Winnipeg have selectively been given coordinating responsibility through the Home Care Office located in the hospital. There are four out of the nine city hospitals that have a coordinating function assigned to them. The criteria for determining when an individual would be coordinated by a hospital designated program is where the individual's ability to function in the community is directly related to his/her ability to access medical care in the hospital immediately. The programs that currently are coordinated through Hospital Home Care Offices are the Home Oxygen Program, Home Ventilator Program, Intravenous Antibiotic Therapy Program, Peritoneal Dialysis Program, and two Palliative Care Programs. The Childrens Hospital in the City of Winnipeg coordinates children who fall into any of the above mentioned categories and who primarily receive treatment and care in the Childrens Hospital.

The Government of Manitoba has established eight geographic areas called "regions". Winnipeg Region is one such region and has been described earlier. The regions outside of Winnipeg (seven in total) have the responsibility for coordinating the short term and long term components of the Home Care Program. The volume of Home Care cases outside of the City of Winnipeg is manageable so that only one coordinating agency had to be designated per region. In addition, most of the regions outside of Winnipeg have designated District Health Centres. The centres are free standing entities that report through the regional structures for the delivery of comprehensive health services in the designated geographic area. These health centre have been designated as Home Care coordinating agencies where they exist.

Financial Systems

Funds for home care services are voted by the Manitoba Legislature and are identified in the budget as Home Care Assistance budget. The Office of

Home Care allocates a portion of these funds to each coordinating agency or region. A computerized record of expenditures by region/agency and coded by service type is made available monthly to each region/agency and to the Office of Home Care. This permits monthly, quarterly, semi-annual and annual analysis of trends and expenditures. Diagram 5 shows the allocation for the Provincial Home Care expenditures at 3% of the total health care budget for 1990/91. This represents approximately 54 million dollars for "in-home services".

Management Information Systems

At this time, the Program information is gathered manually which results in a grossly inadequate system. The Home Care Program is awaiting final approval of a proposal to completely automate a client driven program management information system. The purpose of the system is to collect and analyze cases and service utilization information to the extent that can and will be used with expenditure information for program accountability, program reporting, program evaluation, program planning and program budgeting. All data (case coordination, service utilization, expenditures) are collected for each coordinating agency (regional health centre, Victorian Order of Nurses, hospitals and regions) and for designated geographical areas served by these agencies. This permits analysis of data and trends to the local area, the region, agency and to the province as a whole for operational planning at an area, regional, and provincial level.

An Overview of the Program

Home Care is a coordinated care service program which provides a broad range of services to meet the needs of the persons who require assistance or support in order to remain at home or whose functioning without home care is likely to deteriorate making it impossible for them to stay at home in the community. Upon identification of need (as defined in the program assessment) services are organized in order to avoid deterioration and to maintain and enhance health. The Program intent is to provide services

which will allow the individual to remain in their own home as long as possible and to attain the highest level of independence with the minimum service at the most appropriate level of service provided. This program is offered to all residents of Manitoba and is part of the health care services available in the Province (no consumer charge).

Home Care Referrals

Anyone can make a referral to the Home Care Program. This is a community based nonmedical model for care at home. There are two formal routes for referral in metropolitan Winnipeg: the hospital system, i.e. the Home Care Program has offices in all of the nine city hospitals in order to ensure rapid access to the home care system. There are community service offices at the neighbourhood level in metropolitan Winnipeg. These offices are regional service offices for all government services delivered within the City of Winnipeg. The remaining areas of the Province have government service buildings in which the Home Care staff are usually located. Local hospitals in the rural area receive services from the community Home Care Program on a regular scheduled basis. Generally, the rural hospital does not have designated Home Care staff or a designated Home Care office as the volume of discharges does not justify the need. For referrals received in hospital, the Home Care office in the hospital does the initial assessment to determine eligibility and subsequently establishes a two week care plan which is to be reviewed upon entry into the community system. At the community level referrals are responded to by staff in the Home Care Program. Diagram 6 demonstrates the process described above.

Eligibility Criteria for Home Care

The following criteria are established:

1. Patients who are discharged from hospital who could convalesce at home and be discharged with Home Care supports.

2. Persons who require care in a personal care home but who could be cared for at home as an alternative to entry into a personal care home.
3. Individuals who would be at risk of having to leave their own home and enter the health care system at higher cost. The concept that is being supported is "an ounce prevention is worth a pound of cure".

Assessments

Home Care Assessment

These are comprehensive and multidisciplinary in nature. They are done by professional nurses and professional social workers. There is provision to purchase physiotherapy and occupational therapy for assessment and/or treatment services. Referrals are made to Geriatric Assessment Units both "in patient" and "day hospital patient" services on a regular basis. Psychiatric consultations are available. Additionally, mental health, mental retardation, family services, and public health nurses are all available to participate in consultation, assessment and ongoing services to individuals. The assessment determines eligibility for the Program and further identifies need, in the area of clinical status, health functioning, social functioning and environmental support. The assessment identifies activities basic to household, health, personal and social need which the person can perform, the activities which family members are performing or can realistically perform, the activities for which resources exist in the community or through other government services and the residual requirements to which the Program will have to respond. Document A is the case assessment form currently used by the Home Care Program.

Entry Into Personal Care Home

The Home Care Program is based on a single entry system for care needs. The program has a mandate for assessment for entry into personal care

homes (nursing homes) and for care in the community. The case coordinators for the individual care plan in the community are the same staff who follow the client to the entry point of the personal care home. In Manitoba, the Health Services Commission pays for the care portion of the placement in personal care home and the individual client is expected to pay a "residential" per diem cost. The residential per diem cost is designed as a board and room cost. It is based on the Old Age Pension and Guaranteed Income Supplement (Federal income programs for the elderly) so that all people over the age of 65 would have minimal disposable income after payment in the facility. For individuals under the age of 65 the Income Security/Social Welfare system makes provision for payment. Manitoba Health assumes the responsibility for licensing of personal care homes, establishing standards, monitoring and reviewing the standards. The Ministry is the vehicle through which Government pays for care in the personal care home.

The Care Plan

The care plan flows from the assessment process. Care plans use the data from the assessment. A standard care plan contains behavioural objectives, that are client specific, time measured and behaviourally oriented. They also include the activities required, the level, frequency and nature necessary to support the objectives which are being planned. Where possible, care planning is engaged in by the individual and the family members or the primary support system to the individual. The actual care planning process begins at the assessment stage, follows to the development of the plan, the identification of the case coordinator, the implementation of the plan, the evaluation and adjustment of the plan.

Care plans are to be reviewed every 90 days as a Program standard. When one is unable to meet this standard there is a consequence. People may be under or over serviced as a result of lack of individual review and subsequent reassessment. Over serviced clients are those people who receive more service than what is required in order to ensure adequate and minimal safety and care needs are met. Under serviced people are those

who do not receive enough to ensure adequacy or safety. Clients who are underserved will often call the coordinator and ask for an adjustment rather than waiting for a review and reassessment. Clients who are overserved will sometimes recognize this and ask for decrease in service or indicate that they no longer need the service, however, more often than not they will continue to receive this service until the case coordinator finds time to do the review.

The Program distinguishes between a review and a reassessment process. Reviews take place in order to determine if there is a need for a reassessment, to determine if the care plan is working accordingly and to see if any systems require changing. The reassessment entails the clinical, functional, health and environmental assessment to see if major changes have taken place and/or if new objectives and new care plan or changes within the existing care plan have to be made. The reassessment is coordinated by the case coordinator but may be done by a variety of disciplines or one specific discipline, i.e. nursing or the physician or the social worker as the objectives in those areas may need to be reassessed.

The Case Coordinator

The Case Coordinator has a primary role of facilitator. The case coordinator is the case assessor and the care planner but has the role on an ongoing basis for ensuring that all activities required in the care plan are met. They are not the case manager, i.e. they are not responsible for making all decisions as required, they are responsible for facilitating the decision making process to ensure that the appropriate needs are being met. As an example, social workers can not and do not have the authority and responsibility to make nursing decisions and vis-a-versa. Where discipline decisions must be made with regard to an assessment and/or assessed need the case coordinator has the responsibility to ensure that the necessary consultation occurs and/or that the necessary assessments and actions are taken. They are not responsible for taking the action themselves as it may be beyond the range and scope of their knowledge and skill base. However, as the case coordinator, they are responsible for facilitating the ongoing

provision of the care plan. All communication and information is channelled through the case coordinator. They are the pivot point of access to the care plan and to services required by the client on the program. The case coordinator is the client's primary contact person to ensure all things are working well. The case coordinator has complete authority for the authorization for all services required and for the authorization of payment for the services up to the cost limit as defined by the Program.

Home Care Services

Diagram 8 is provided as a broad overview of the range and scope of service as well as level of service provided. The majority of service provided is through the direct service providers who are directly employed by the Program and are on a direct service payroll. Currently there are labour agreements with the staff employed for provision of service in the home. The labour agreements provide benefit programs for the workers in addition to working conditions being established. Beyond employing direct service staff in metropolitan Winnipeg, the nursing service is purchased directly by a contractual arrangement from the Victorian Order of Nurses. Physiotherapy and occupational therapy are purchased on a fee for service billing across the Province from a community therapy service organization. The dollars for the range of service agreements are managed through the Home Care Assistance budget. There are approximately 4,000 staff employed across the Province. They are casual employees who are paid hourly rates based on the number of hours worked.

The direct service employees are managed through a system of resource coordination. There are resource coordinators available at the local neighborhood level who function as supervisors of the direct service employees, and who arrange the scheduling and the work assignments of these direct service workers. The resource coordinators work with the case coordinators in ensuring that the direct service component of the Program is provided according to the specifications of the case coordinator in the Home Care Program.

Special Programs

Personal Care Home Bed Replacement

Home Care services are normally delivered in the client's home to support individuals and families with illness and disability and thereby enabling them to continue living in the community. In response to requests from a small number of severely physically handicapped people to live in the community, the Home Care Program developed an alternative means of delivering care at home. This is currently referred to as "group shared care" in independent housing. This service model is within the existing Program Policy parameters in respect to eligibility for service, assessment for need, service and cost limits. The individuals involved have care needs spanning 24-hours per day. They cannot be cared for individually within the Home Care cost limits. By agreeing to group share their assessed care hours, these individuals have been able to return to and/or remain in the community within the existing parameters of Home Care. An example of group shared care implemented to-date is:

Fokus Housing - There are four distinct groupings involving 43 individuals. Each group is located in an apartment building in Winnipeg. The care site is managed by a non-profit corporation on behalf of the tenants. The tenants have substantial input in the management of their care and a selection of replacement tenants when vacancies occur. Although severely disabled, tenants assume full responsibility for the management of their own lives. Staffing is available on site 24-hours per day and has capacity to respond on scheduled intermittent basis throughout the day (24-hour clock). The individuals in the group shared project demonstrate the use of multisectoral resources, eg. the Department of Housing, the Department of Health and in some instances the Department of Family Services for Income Security purposes. All of the individuals involved in these projects would otherwise be accommodated in personal care home beds. The average length of stay of these individuals with regard to life span has not yet been determined. There are individuals

who entered the first group shared project in 1975. They are all alive and continuing to live either in existing Fokus Units or with the spouse or primary caregiver elsewhere in the community.

Hospital Service Replacement and Hospital Bed Replacement

The hospital service replacement and hospital bed replacement services have provided care to persons who require complex health and social services. Some examples have been clients on ventilators, clients requiring antibiotic intravenous therapy and clients on continuous oxygen (24-hours per day). These people are beyond the care levels available in the personal care home program. Although, they are relatively few in number, they consume a disproportionate amount of service and therefore are high cost patients. The hospital coordinator will transfer the case to one of the rural regions and to a case coordinator in the rural region but there will be a medical link with the local rural hospital. The programs have often been initiated by the hospitals with the expectation that Home Care will expedite the service delivery for care at home. The mandate and scope of the Home Care Program have been exceeded in assuming program responsibility for the above services. This has been recognized and at this time we are waiting further direction regarding the extension of Home Care services to assume more hospital bed and hospital replacement programs.

Program Controls

(a) Cost Limits

The Program has controls with which the case coordinator must abide. The case coordinator may authorize service in the client's home up to the alternative care facility cost. Case coordinators are provided with the unit cost of the caregiver by staff category and the unit cost for services purchased by the Home Care Program. These costs are established by the central Home Care Office. The case coordinator is responsible for determining the alternative care facility

and the level of care the individual would require if they were in that facility. The alternative care cost is the personal care home cost in the Home Care Program. The cost may be exceeded by policy and with supervisory approval at the local level in the following areas:

Where there is a short term need for the individual to exceed the cost limit in order to continue to remain in the community.

The situations that typically fall in this category are:

- i) individuals with chronic diseases who have an exacerbation and who require assistance to prevent short term hospitalization
- ii) individuals whose primary care giving system encounters a major unplanned change, i.e. death or illness of the primary caregiver. Usually the program continues to maintain the person in the home until alternative arrangements can be made.
- iii) where the individual has been panelled, i.e. accepted for placement into the personal care home but where there is no bed available and the individual is being maintained in the community pending placement in a personal care home.

These circumstances all fall within existing policy. There are instances when policy has been exceeded, i.e. the cost limits are exceeded on an ongoing basis for individuals who are not able to be maintained in personal care homes (their needs exceed the level of care available in the personal care home) or individuals for whom personal care home placement is not appropriate, i.e. they are very young, mentally intact and still have young families with whom they are connected in the community.

(b) Service Limits

The Home Care Program is a support program designed to prevent individuals from having to enter hospital and/or an alternative care institutions. At the point the individual requires an institutional staffing pattern or exceeds reasonable service levels (i.e. nursing service 2 or 3 times per day, management of unsafe behaviour, monitoring or evaluation on an hourly basis), such care would be considered in excess of what a support service would normally provide in a community setting.

(c) Reviews

There are case reviews done by the case coordinator. As indicated earlier these reviews are to be done every 90 days. They are to ensure that the care plan is appropriate and required. There are caseload reviews organized by the Regional Home Care Coordinator or the Program staff of the coordinating agency. The caseload reviews evaluates types of cases in order to ensure consistency and appropriate application of service delivery policy. They further identify areas which need change or addressing at the regional level or at the Provincial Program Policy level. The information from these reviews also forms part of the data base that the region or coordinating agency use in developing areas for staff development, staff training, service delivery changes and budget management. Program reviews are developed and managed by the central Provincial program office. The Program reviews are designed to look at categories of policy within the program to ensure policy and procedures continue to be met and to ensure the Program is being applied appropriately and providing the intended impact. The reviews are used additionally to develop areas for program change, policy change and overall monitoring of program delivery.

(d) **Monthly Program Reporting**

The coordinating agencies and regions submit monthly reports to the central Home Care Office. These reports provide information regarding clients served, resource utilization, by service category and number of units provided, the number of discharges to the Program, the number of admissions to the Program, the number of people panelled, assessed for personal care home placement and placed. In addition, there are monthly variance reports regarding monthly cash flows and expenditures. The variances must be identified and explanations provided.

Factors Impacting on Home Care Development

From the inception of the Program in 1974 until the early 1980's, the Program essentially did the job that it was designed to do. It provided support care in the community to prevent access or delay access to higher cost health care services. In the early 1980's developments took place across many sectors in health care and in communities in general that impacted and were impacted on by Home Care Program:

1. Communities and community resources were provided funding specifically targeted to seniors, i.e. Support Services to Seniors, Services to the Well Elderly, New Horizons Programs, Transportation Systems. These initiatives benefited the Home Care Program by delaying the number of elderly that would have come into the Program as they were now provided with resources to meet their needs from within their own communities and Home Care was not needed. This development raised the acuity level at the point of entry into the Home Care Program.
2. Physically handicapped advocacy groups across Canada and in Manitoba specifically took major initiatives in advocating to government to provide increased opportunities for the physically handicapped to continue or begin to live in independent or group-

shared care community settings. The Home Care Program was impacted on by creating service delivery models for young physically disabled.

3. Improved technology made a major impact on Home Care, particularly, high technological care developments, eg. ventilators, dialysis equipment, oxygen concentrators, etc. The impact on Home Care was to extend service delivery in the community to clients who require these supports. This demands staff trained to higher skill levels, more units of service per individual served, more complex care and planning due to complexity of the individual situation.
4. Technology in hospital, physician patterns of practice have caused Home Care to provide higher intensity of service, a broader range of service and a different skill training to service providers in order to accommodate a different mix of client population.
5. Change in patterns of health care delivery by physicians and hospitals. Hospitals facilitated earlier discharge into the community. Physicians have begun to use more outpatient surgery, day surgery. The impact on the Home Care Program has been more units of service per person served, sicker and/or older and frailer individuals requiring Home Care in place of hospital, or to convalesce at home on personal care home.
6. There was a noticeable shift in level and type of care being provided in the personal care home system. The majority of residents require care at the maximum end of the care levels. This has created an impact on Home Care as persons previously at light and medium levels of care, expected to be cared for in personal care homes, are now cared for at home.
7. There have been bed reductions in the personal care home sector, as well as the acute care sector selectively across the province. This has had an impact on Home Care as the Program has been providing more intensive service to individuals who otherwise would have

institutional care. It has also meant more high level care being delivered through the Home Care Program to replace institutional beds that no longer exist.

8. Labour costs have grown steadily as a result of union agreements and benefit programs for all direct service workers in the Home Care Program.
9. To-date, there are no "capping" measures that have been taken with regard to service provision or numbers of clients the program can be funded to serve. All persons eligible will receive care with the expectation that the Program will find the ways and means to meet the need.

All of the above actions took place generally in isolation from one another, however, they universally impacted on Home Care Program. Today Home Care provides hospital replacement services, as well as hospital bed replacement services, and personal care home bed replacement services. As a result, the money and resources that were developed for the target population and the primary objective has been slowly eroded over the past 5 years.

Issues for the Home Care Program

To-date no one has defined or set limits to the boundaries of community care. The primary area of concentration has been on providing support care to individuals to remain in the community. It is likely that the money and resources developed for the target population will continue to be eroded if the community care system has to respond to both support care programs for the elderly and primary care programs for the hospital and chronic care facility discharges.

If Home Care is to remain a program primarily focused on meeting the needs of the elderly in the community care system, service will have to be expanded in the area of support to primary caregivers who themselves are

becoming older and frailer (see diagram 9). More ways of providing community based service to cognitively impaired clients will have to be developed (approximately one third of the clients on Home Care are cognitively impaired). Home Care will have to be prepared to meet increased needs of larger numbers of the old, old population (85 years plus). This is the population who use the Home Care system as an alternative to personal care home placement to an ever increasing amount (diagram 9 - Manitoba population projections). It is this population additionally who use higher percentages of service in order to receive the support required to continue to remain in their own home. The Program capacity to respond to the younger disabled and handicapped population's need and expectation of having a lifestyle of self directed and self managed care in a "managed care at home system" for sick, old and frail people often produces conflicts. How the resources dedicated to the community care system for the elderly be equitably distributed amongst the above named populations?

Risk assessment risk management for both the program and the client population must be more specifically examined and articulated as the program becomes involved in more and more complex care. Ways and means of pursuing cost containment exercises continue to be the greatest challenge facing the Home Care Program.

The Results of Home Care in Manitoba

The Home Care Program continues to remain cost effective as an alternative to personal care home placement for the elderly in the Province of Manitoba. Diagram 13 shows the cost comparisons for personal care home placement and Home Care services per person served for the year 1990/91. The Home Care Program has continued to impact on the personal care home bed ratios per 1,000 population 75 and over. Diagram 11 demonstrates the steady decline in the personal care home bed supply per 1,000 population age 75 and over. There are noticeable variations year-to-year in this diagram. The variations reflect the development of an additional community based resources which have delayed the entry of individuals into the Home Care Program. The "other elderly" (86.8%) in the Province of Manitoba use

their own informal support networks or general community services in order to carry on functioning. The question asked of all case coordinators as they admit clients onto the Program is the following: "In the absence of the Home Care Program where would you see the client's needs being met?" Diagram 12 clearly indicates the response to the question for the individuals who are enrolled on the Home Care Program. Three quarters of the clients being admitted to the Home Care Program today would require institutional care if the Home Care Program was not available. The Home Care Program has demonstrated cost effectiveness to the health care system in the area of capital costs and construction of personal bed home beds, as well in the delivery of care to individuals in their own home setting. The Program has demonstrated the viability (economically and effectively) of long term and short term care in community settings.

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APPENDIX

Documents

- A - Case Assessment form for Home Care used by Case Coordinator
- B - Services to Seniors in Manitoba
- C - Highlights of Manitoba Programs for the Elderly (1956-1985)
- D - Chronology of Long Term Care in Canada and Manitoba

Diagrams

- 1. Projected Population 65 + and Projected % Population 65 + for Canada
- 2. Government of Manitoba Organization and Structure - Functional Relationship
- 3. Ministry of Health - Province of Manitoba
- 4. Manitoba Population 65 + (1988, 1989, and 1990) (bar graph)
- 5. Manitoba Health - Main Estimates of Expenditure
- 6. Referral Process - Home Care Program
- 7. Program Delivery Process
- 8. Continuing Care Program - Home Care Services
- 9. Projected Population 65 + and Projected % Population 65 + for Manitoba
- 10. Manitoba Population 65 + (pie graph)
- 11. Home Care Caseloads, Total Served per 1,000 Elderly and Nursing Home Bed Supply 1984/85 to 1990/91
- 12. Care Level Equivalent of Persons Admitted to Home Care 1990/91
- 13. Annual Cost per Person Served; Personal Care Homes and Home Care 1990/91
- 14. Functional Model of the Manitoba Continuing Care Program
- 15. Provincial Program Management
- 16. The Provinces of Canada

**Manitoba Home Care Program
Care Assessment Form**

 Manitoba
Health


Applicant's Name		Phone No.	Date
Address		Postal Code	Home Care No.
TYPE OF ASSESSMENT ☐ Admission ☐ Reassessment		Co-ordinator	
Location where assessment completed (own house, hospital, etc.)		Agency	

FAMILY INFORMATION/FUNCTIONAL ASSESSMENT

1 Who lives in same household with applicant? (If none, write "none" in space.)

Name	Age	Relationship	REMARKS: (Indicate if supportive of applicant and how.)

 2 List relevant family members. (If none, write "none" in space.)
Please check (✓) next of Kin or local person responsible.

Please check (✓)	REMARKS: (Indicate distance, frequency of contact, supportiveness of applicant and how.)
Name	
Address	
Name	
Address	
Name	
Address	
Name	
Address	

3 Any additional information/assessment re family functioning pertinent to assessment for/delivery of home care:

HOUSEHOLD INFORMATION/FUNCTIONAL ASSESSMENT

4 APPLICANT LIVES IN ☐ House ☐ Rooms ☐ Apartment ☐ Senior Citizen Housing ☐ Family Care/Foster Home

☐ Other (specify) _____ REMARKS: _____

5 INDICATE FACILITIES AVAILABLE AND ADEQUACY

	Available (type)	Adequacy (yes, no, if no explain)
HEATING		
COOKING		
REFRIGERATION		
LAUNDRY		
DRYING		
WATER		
TOILET		
BATHING		
STAIRS		
TELEPHONE		

6 Indicate if any of above facilities (including their location) affect the ability of the applicant to function in home or to get outside:

7 Indicate if any of above facilities (including their location) will affect the need for and delivery of services in the home:

8 HOUSEHOLD TASKS/MANAGEMENT	Formerly Done By Applicant Yes/No	Still Done Yes/No	REMARKS: Where still done indicate any limitations, also where not done but if formerly done indicate why not done and specify who (if anyone) now does it.
LIGHT CLEANING			
HEAVY CLEANING			
PERSONAL LAUNDRY			
HOUSEHOLD LAUNDRY			
SHOPPING			
FULL MEAL PREPARATION			
LIGHT MEAL PREPARATION			
USE PHONE			
MANAGEMENT OF OWN AFFAIRS			

9 Any additional information/assessment re household functioning pertinent to the assessment for/delivery of home care:

HEALTH INFORMATION/HEALTH FUNCTIONAL ASSESSMENT

10 MAJOR CLINICAL FINDINGS: (Do not repeat if on basic information sheet.)

Diagnosis/Extent of Disability:

Diagnosis Known:

To Family ☐ Yes ☐ No

To Applicant ☐ Yes ☐ No

11 CLINICAL HISTORY:

12 ALLERGIES: if any, describe

[illegible]

Ability to Administer: Independent ☐ Requires Assistance ☐ Specify _____

Compliance:

14 Current prescribed treatments, if any: Indicate applicant's ability to manage own treatment.

Independent ☐ Requires Assistance ☐ Specify _____

15 Have clinical findings/treatment been confirmed with attending physician? ☐ Yes ☐ No

If Yes, how. If No, what is the plan for confirmation?

16 **NUTRITION:** Is applicant eating adequately: ☐ Yes ☐ No Is applicant on special diet? ☐ Yes ☐ No
COMMENTS:

17 Any additional information/assessment re physical health functioning pertinent to the assessment for/delivery of home care:

PERSONAL CARE INFORMATION/FUNCTIONAL ASSESSMENT

REMARKS:

Should reveal any patterns/inconsistencies;
Should include any current or planned treatment/intervention;
Should cover implications for self care, for socialization.

18 SIGHT:
Wears glasses ☐ Yes ☐ No

- ☐ Adequate for all activities
- ☐ Inadequate for some activities (specify)
- ☐ Inadequate for personal safety (specify)

REMARKS:

19 HEARING:
Wears hearing aid ☐ Yes ☐ No

- ☐ Adequate for all activities
- ☐ Inadequate for some activities (specify)
- ☐ Inadequate for personal safety (specify)

20 COMMUNICATION:
☐ Gestures only ☐ Written only

- ☐ Adequate for all activities
- ☐ Inadequate for some activities (specify)
- ☐ Unable to communicate

- 21 AMBULATION:**
- ☐ Independent with or without mech. aid
 - ☐ Outdoors with assistance
 - ☐ Indoors amb. with assistance
 - ☐ Stairs with assistance
 - ☐ Stairs independent
 - ☐ Cannot manage stairs
 - ☐ Wheelchair independent
 - ☐ Wheelchair with assistance

22 TOILETING

CONTINENCE

MANAGEMENT

- | | |
|--|--|
| ☐ Completely continent | ☐ Independent |
| ☐ Incontinent urine, occasionally | ☐ Dependent (elaborate) |
| ☐ Incontinent urine, night only | ☐ Catheter |
| ☐ Incontinent urine, always | ☐ Ostomy |
| ☐ Incontinent feces, occasionally | ☐ Condom Drainage |
| ☐ Incontinent feces, always | ☐ Bathroom Routine |
| | ☐ Other Aids |

23 TRANSFERRING: ☐ Independent ☐ Bed to chair with assistance ☐ Bedfast, can turn self in bed ☐ Bedfast, must be turned in bed	REMARKS:
24 EATING: Dentures: ☐ Upper ☐ Lower ☐ Independent ☐ Requires assistance or encouragement ☐ Has to be fed	
25 DRESSING: ☐ Independent ☐ Requires assistance or encouragement ☐ Has to be dressed/undressed	
26 BATHING: ☐ Independent ☐ Can sponge bath self ☐ Can bath only with assistance or encouragement ☐ Has to be bathed	
27 CARE OF HAIR: ☐ Independent ☐ Requires assistance or encouragement ☐ Cannot care for own hair	
28 FOOT CARE ☐ Independent ☐ Cannot care for own feet ☐ Requires Assistance	
29 CARE FOR PROTHESIS: Where applicable, indicate type of prothesis and ability of applicant to care for such.	

Any additional information/assessment re personal care functioning pertinent to the assessment for/delivery of home care:

PSYCHO/SOCIAL INFORMATION/FUNCTIONAL ASSESSMENT

30 Has applicant's living pattern/role in family or household altered in past year? Describe showing whether there has been change or loss and indicate whether (how) applicant is coping. Look for indicators of loneliness, bereavement or loss of status.

31 Describe how applicant spends his/her time in a typical day at home and indicate if applicant describes his/her activities as being meaningful to others, to self or simply as a means of passing time.

32 Are there any activities which the applicant formerly was engaged in at home which he/she now misses? Why? Could the applicant be involved again in the same or similar activity with assistance/intervention? What?

33 Neighbours, friends in contact with applicant:		REMARKS: (Indicate frequency of contact and supportiveness to applicant and in what way.)
Name	Phone #	
Address		
Name	Phone #	
Address		
Name	Phone #	
Address		
Name	Phone #	
Address		

34 Describe applicant's involvement in community (include church, legion, fraternal, etc.)

35 Are there any community activities in which the applicant formerly was involved which he/she now misses? Could the applicant be involved again with assistance/intervention? What?

36 Does travel outside the home affect applicant's ability to participate in activities, to receive medical care, to manage the household, etc.? If so, describe why, how and intervention indicated.

37 Specify cultural/religious preferences of applicant relevant to delivery of home care services (language, special food, etc.)

REMARKS:

Should reveal any patterns/inconsistencies;
Should include any current or planned treatment/intervention;
Should cover implications for self care, for socialization.

38 **MENTAL STATUS:**

- ☐ Completely oriented
- ☐ Forgetful/confused occ.
- ☐ Disoriented

REMARKS:

39 **MOOD:**

- ☐ Seems content
- ☐ Seems concerned about specific problem
- ☐ Seems somewhat tense and anxious
- ☐ Seems depressed
- ☐ Unusual, unpredictable behavior (specify)
- ☐ Not motivated for some activities (specify)

40 **MOTIVATION:**

- ☐ Motivated for all activities
- ☐ Not motivated for some activities (specify)
- ☐ Not motivated for most activities

41 **JUDGEMENT IN PRESENT SITUATION:**

- ☐ Realistic
- ☐ Adequate for personal safety
- ☐ Limited ability to make judgements
- ☐ Unrealistic

42 Any additional information/assessment re psycho/social functioning pertinent to assessment for/delivery of home care:

SUMMARY ASSESSMENT

Under the following headings indicate the area(s) (if any) where the applicant cannot meet need through self-functioning or through the services of available family or others, and which, if the need is not met, places the applicant at risk of not being able to remain in the community-or-places the applicant at risk of deterioration which could directly contribute toward inability to remain in the community.

Where the applicant's ability to remain in the community is dependent upon the service of others in the household or in the community, show where the relief of such providers is realistically indicated for continued living in the community.

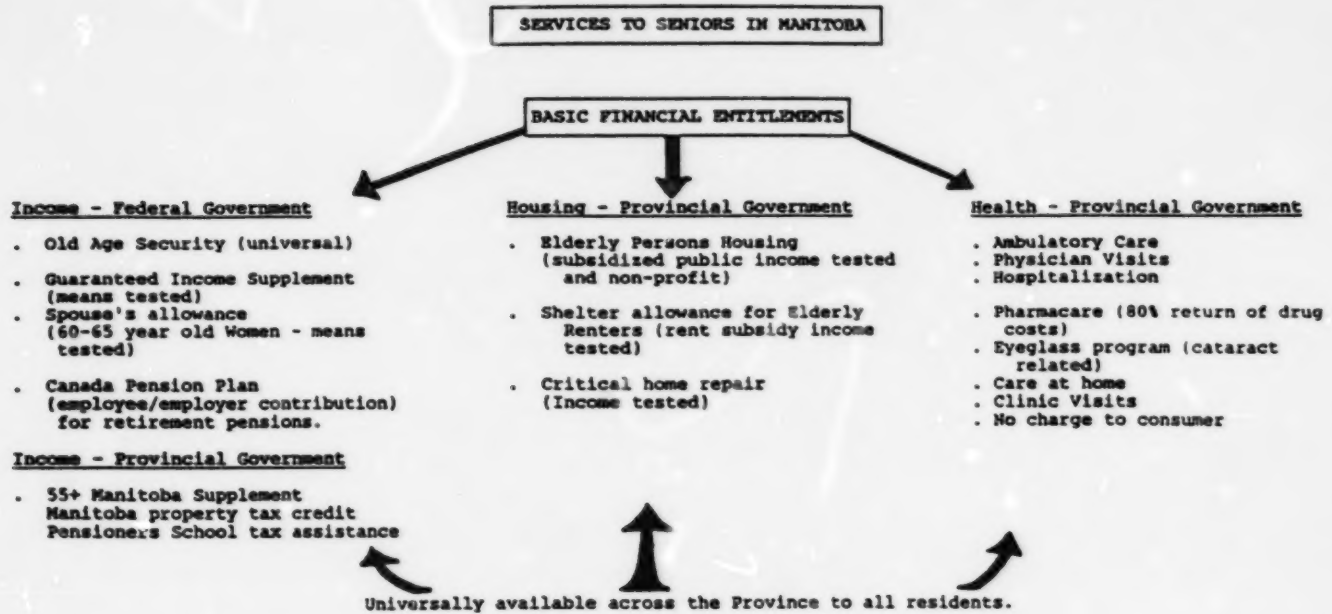
HOUSEHOLD MAINTENANCE NEEDS

HEALTH NEEDS

PERSONAL CARE NEEDS

PSYCHO/SOCIAL NEEDS

SUPPLIES/EQUIPMENT NEEDS



THE STRUCTURES FOR CREATION OF SERVICES TO SENIORS IN MANITOBA

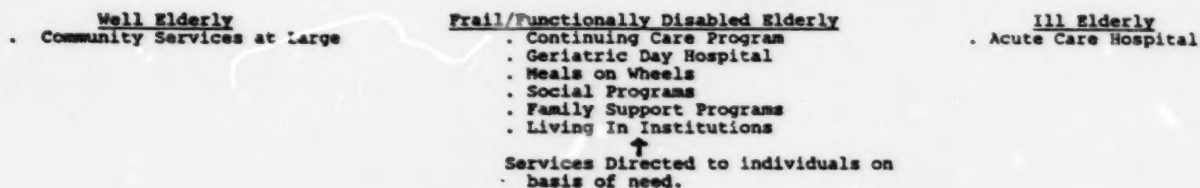
The Federal Government

- I. programs eg. "Discover Choices"
- II. money for program development at the local community level "New Horizons Program"

The Provincial Government

- I. Programs: managed by the Provincial Government:
 - . Continuing Care Program
 - . Personal Care Home Program
 - . Office of Residential Care
 - . Transportation Services
 - . Medical Equipment and Supply Loan Program
 - . Office Public Trustee
 - . Support Service to Seniors
 - . Office of Provincial Gerontologist
- II. Programs financially supported by government through the mechanism of grants to an agency and an agency board
 - . Age and Opportunity:
 - . Counselling
 - . Information and referral
 - . Victim Services
 - . Senior Centres
 - . Seniors Centres (free standing own Board)
 - . Creative Retirement
 - . Manitoba Society of Seniors
 - . Meals on Wheels

CONTINUUM OF SENIORS & SERVICES IN MANITOBA



Services Available to the Community to Support the Elderly

Support Services to Seniors

Through funding and program development assistance provides opportunities for local communities to provide social supports to the elderly:

- . Meals programs
- . Community Resource Programs
- . Tenant Resource Coordinators
- . Volunteer Programs

**HIGHLIGHTS OF MANITOBA PROGRAMS
FOR THE ELDERLY (1956-1985)**

MANITOBA AS A PIONEER IN AGING

- | | | |
|---------|---|--|
| 1956 | - | AGE AND OPPORTUNITY ESTABLISHED |
| 1957-85 | - | FOUR CONFERENCES ON AGING |
| 1960 | - | NOTRE DAME SENIOR CENTRE OPENED |
| 1964 | - | DEER LODGE DAY HOSPITAL OPENED |
| 1971 | - | AGING IN MANITOBA STUDY |
| 1973 | - | INSURE PERSONAL CARE HOMES |
| 1974/5 | - | UNIVERSAL HOME CARE |
| 1978 | - | ADULT DAY CARE AND MANITOBA LONGITUDINAL
STUDY ON AGING |
| 1979 | - | MANITOBA SOCIETY OF SENIORS |
| 1980 | - | RESPITE CARE AND MANITOBA COUNCIL ON
AGING |
| 1982 | - | CENTRE ON AGING - UNIVERSITY OF MANITOBA |
| 1983 | - | PROVINCIAL GERONTOLOGIST AND AGING
FOLLOW-UP STUDY |
| 1984/5 | - | PENSION REFORM ENACTED |
| 1985 | - | SUPPORT SERVICES TO SENIORS INITIATED |

THESE ARE ALL FIRST OF THEIR KIND IN CANADA OFTEN IN NORTH
AMERICA AND ARE HALLMARKS OR MODELS BEING EMULATED BY
OTHERS. WE HAVE A FINE RECORD TO UPHOLD OF WHICH WE CAN BE
JUSTLY PROUD.

CHRONOLOGY OF LONG-TERM CARE IN CANADA
AND MANITOBA

- 1867 - British North American Act established provincial responsibility for medical services.
- 1957 - The Hospital Insurance and Diagnostic Services Act of Canada implemented; provides for hospital services and hospital construction; 1958 - Provincial system of hospital insurance introduced in Manitoba.
- 1958 - Federal cost-sharing program begins.
- 1958/63/66- First, Second, and Third Manitoba Conferences on Aging.
- 1959 - Manitoba Social Allowances Act established health care as an entitlement of the population, service in the home as a necessary option, and the elderly as a discrete category of service recipient.
- 1961 - First Canadian Conference on Aging.
- 1966 - Canada Assistance Plan enacted, providing for 50% cost-sharing from the Federal government for welfare programs.
- 1966 - Canadian Medical Care (Medicare) Act passed; 1969 - Medical (physician services) insurance introduced in Manitoba.
- 1966 - Publication of final report of special Committee of the Senate on Aging. Provided extensive conceptual foundation for future Canadian systems.
- 1969 - Manitoba Medical Services Insurance Corporation becomes the Manitoba Health Services Insurance Corporation, and implements the Canadian Medical Care Act in Manitoba.
- 1970 - Manitoba Health Services Commission replaces
 - (1) Manitoba Health Services Insurance Corporation
 - (2) Manitoba Hospital Commission, and
 - (3) Manitoba Medical Service (a physician-sponsored medical insurance plan).

DOCUMENT D (con't)

- 1972 - Publication of White Paper on Health Policy in Manitoba.
- 1972 - Personal care home insurance legislated in Manitoba.
- 1973 - Personal care home insurance started in Manitoba.
- 1974 - Services to Seniors Program established.
- 1974 - Office of Continuing Care created in Manitoba.
- 1977 - Established Programs Financing Act replaced Federal cost-sharing with redistribution of tax points and formulas for grants to provinces which included equalization factors among provinces. Under this program, the costs of continuing care, home care, and personal care home in Manitoba became eligible for cost-sharing.
- 1983 - Second Canadian Conference on Aging.
- 1984 - The Canada Health Act proclaimed; consolidated and superseded the provisions of the Hospital Insurance and Diagnostic Services Act, the Canadian Medical Care Act, and the Established Programs Financing Act.
- 1984 - Support Services to Seniors Program and projects established.
- 1985 - Fourth Manitoba Conference on Aging.
- 1989/92 - Reports of task forces of Health Advisory Network, many relevant to Seniors.
- 1991 - Integration of Gerontology, Services and Support Services to Seniors, Home Care, Personal Care Homes as the Continuing Care Programs Division reporting to one Assistant Deputy Minister.
- 1992 - Addition of Chronic and Rehabilitation to Continuing Care Programs Division.

DIAGRAM 1

CANADA
PROJECTED POPULATION 65+ AND PROJECTED % POPULATION 65+

YEAR	65-69 % 65+	70-74 % 65+	75-79 % 65+	80-84 % 65+	85+ % 65+	TOTAL
1991	1,064,900 33.6%	821,900 25.9%	626,500 19.8%	386,500 12.2%	271,200 8.6%	3,171,000
1996	1,102,200 30.9%	960,400 26.9%	694,200 19.5%	471,300 13.2%	340,200 9.5%	3,568,300
2001	1,100,200 28.5%	997,200 25.8%	814,100 21.1%	527,700 13.7%	422,900 11.0%	3,862,100
2006	1,174,400 28.4%	1,005,900 24.3%	851,000 20.5%	619,700 15.0%	490,200 11.8%	4,141,200
2011	1,415,100 31.1%	1,065,300 23.4%	852,200 18.8%	643,200 14.2%	568,200 12.5%	4,544,000

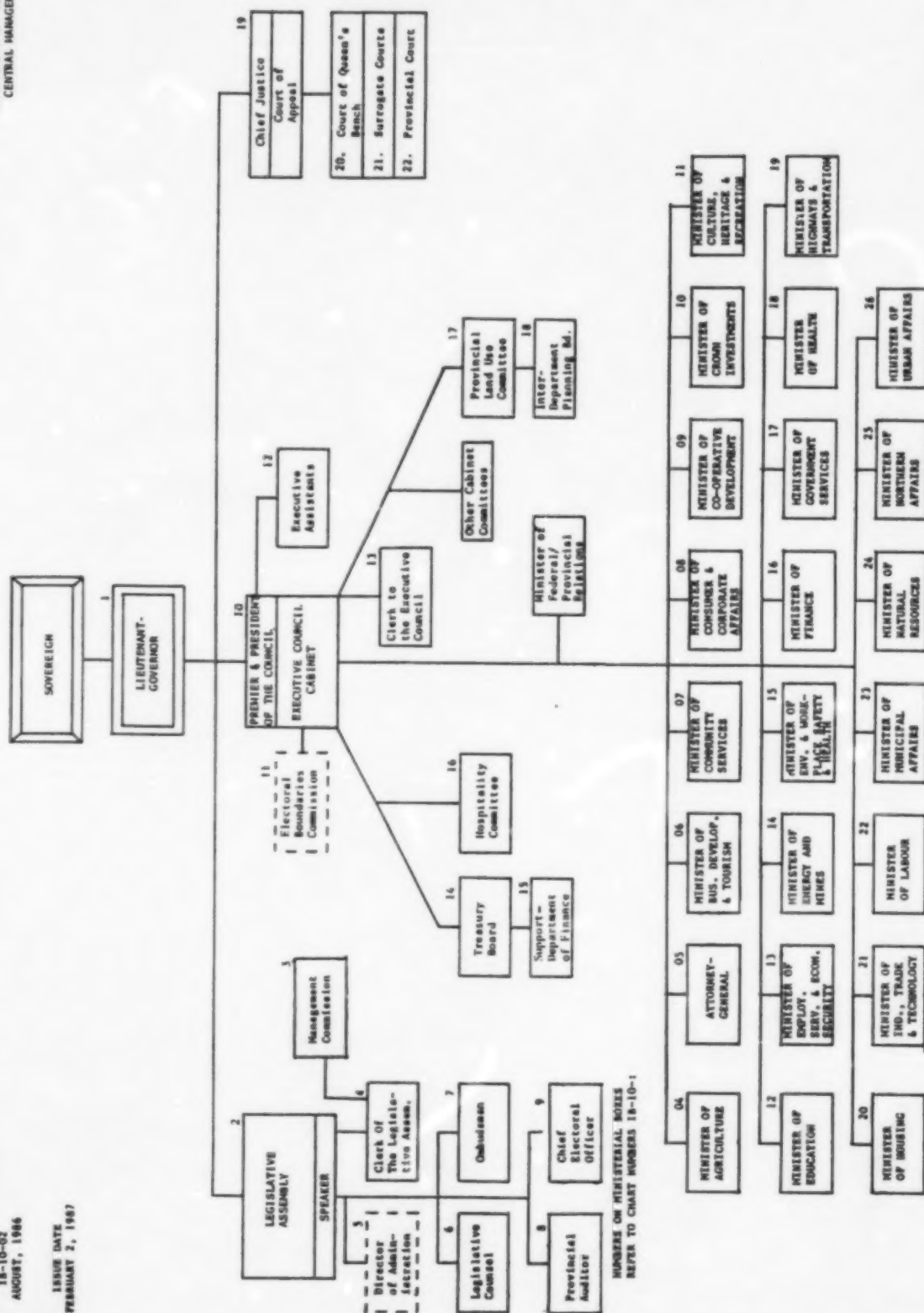
Source: Statistics Canada

GOVERNMENT OF MANITOBA
ORGANIZATION AND STRUCTURE - FUNCTIONAL RELATIONSHIP

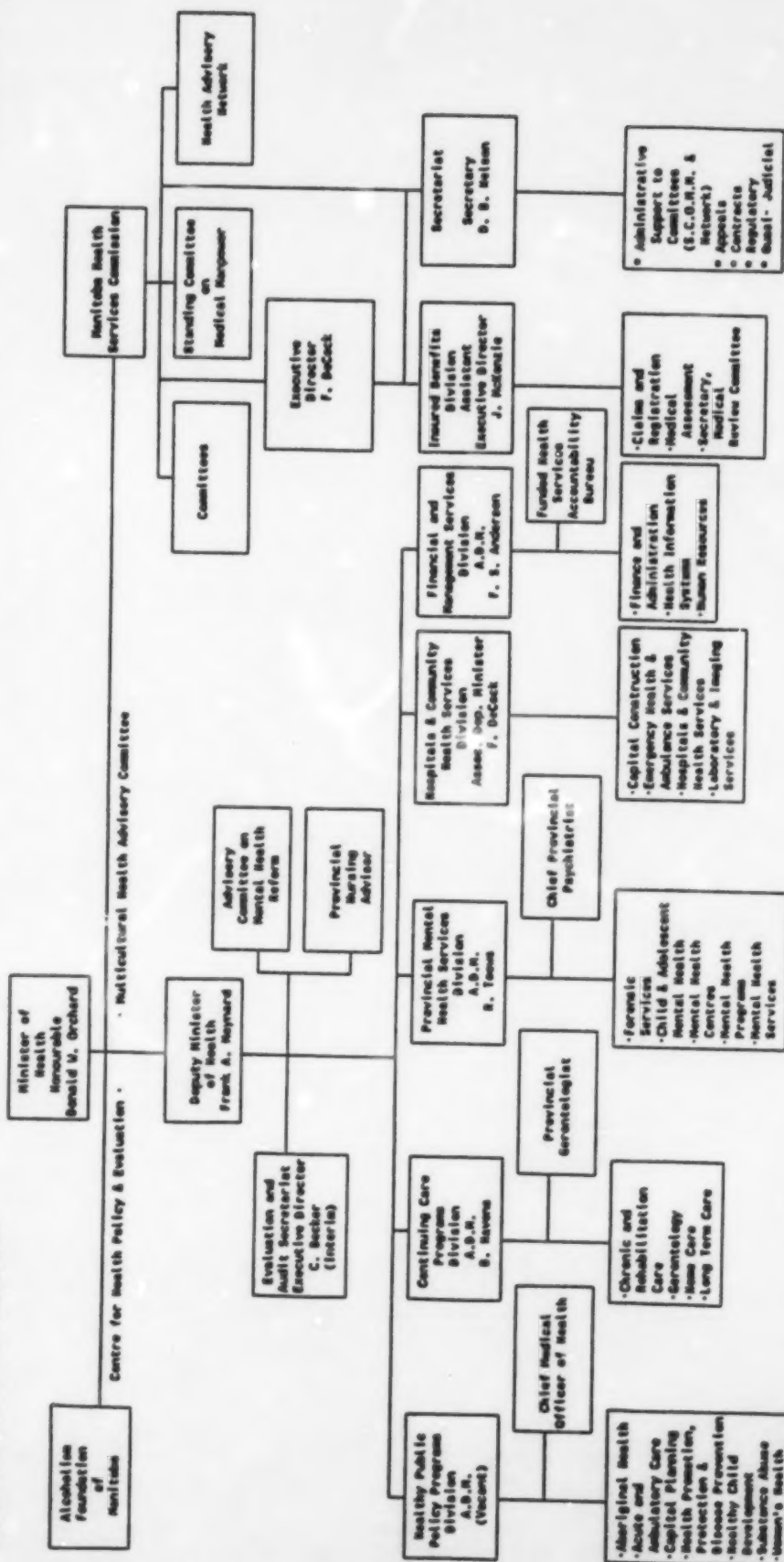
GENERAL MANAGERIAL ADMINISTRATION
18-10-02
AUGUST, 1986

ISSUE DATE
FEBRUARY 2, 1987

GOVERNMENT OF MANITOBA
CENTRAL MANAGEMENT

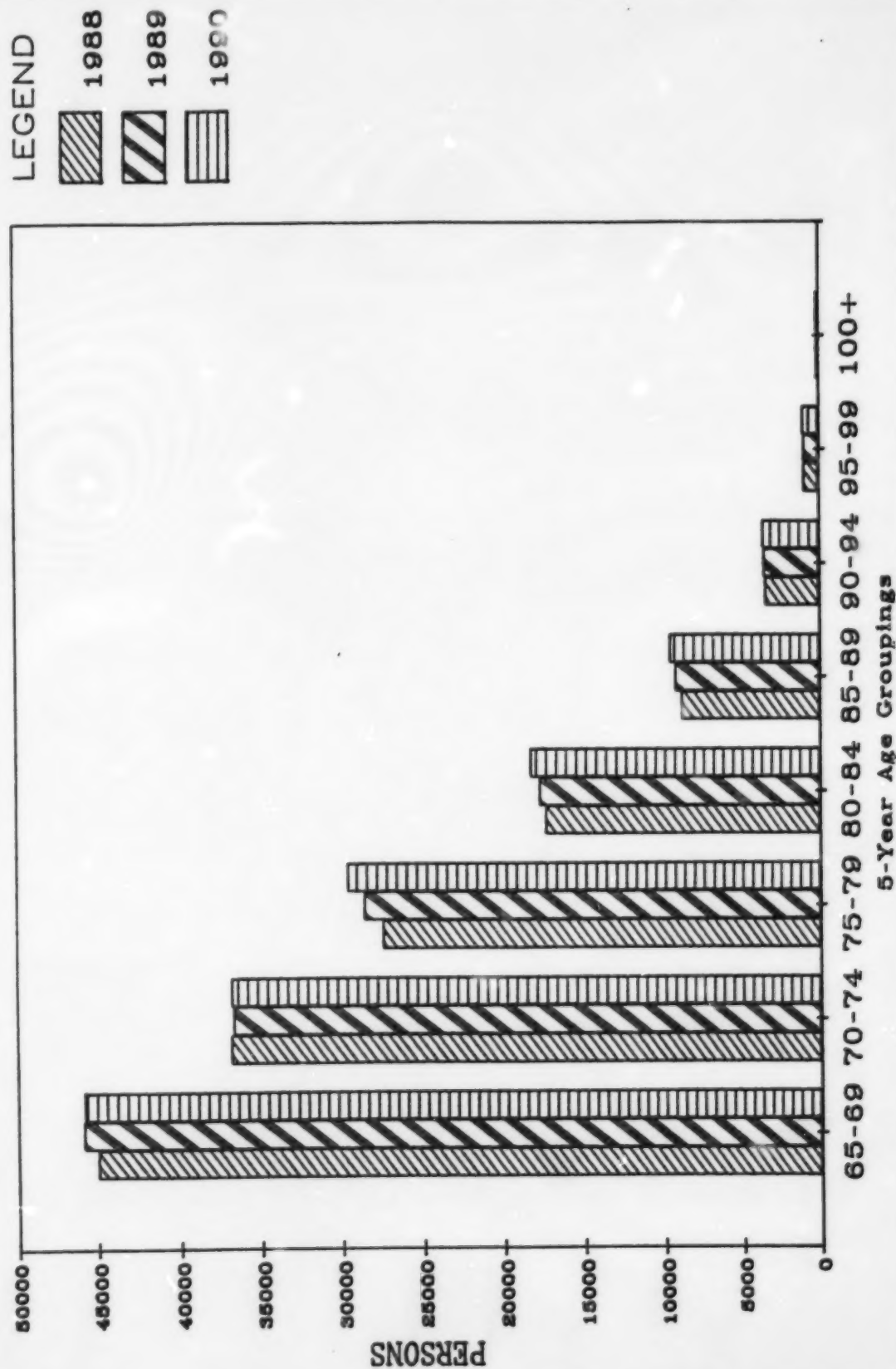


MANITOBA
DEPARTMENT OF HEALTH



Notes: This is a transitional organization chart reflecting responsibility centres and functions. Pending legislative changes, the Associate Deputy Minister retains the title of Executive Director, Manitoba Health Services Commission as well as legislative relationship with the Commission Board.
A.B.N. = Assistant Deputy Minister

MANITOBA POPULATION 65+ June 1, 1988, 1989, 1990



MANITOBA HEALTH 1990/91 Main Estimates of Expenditure

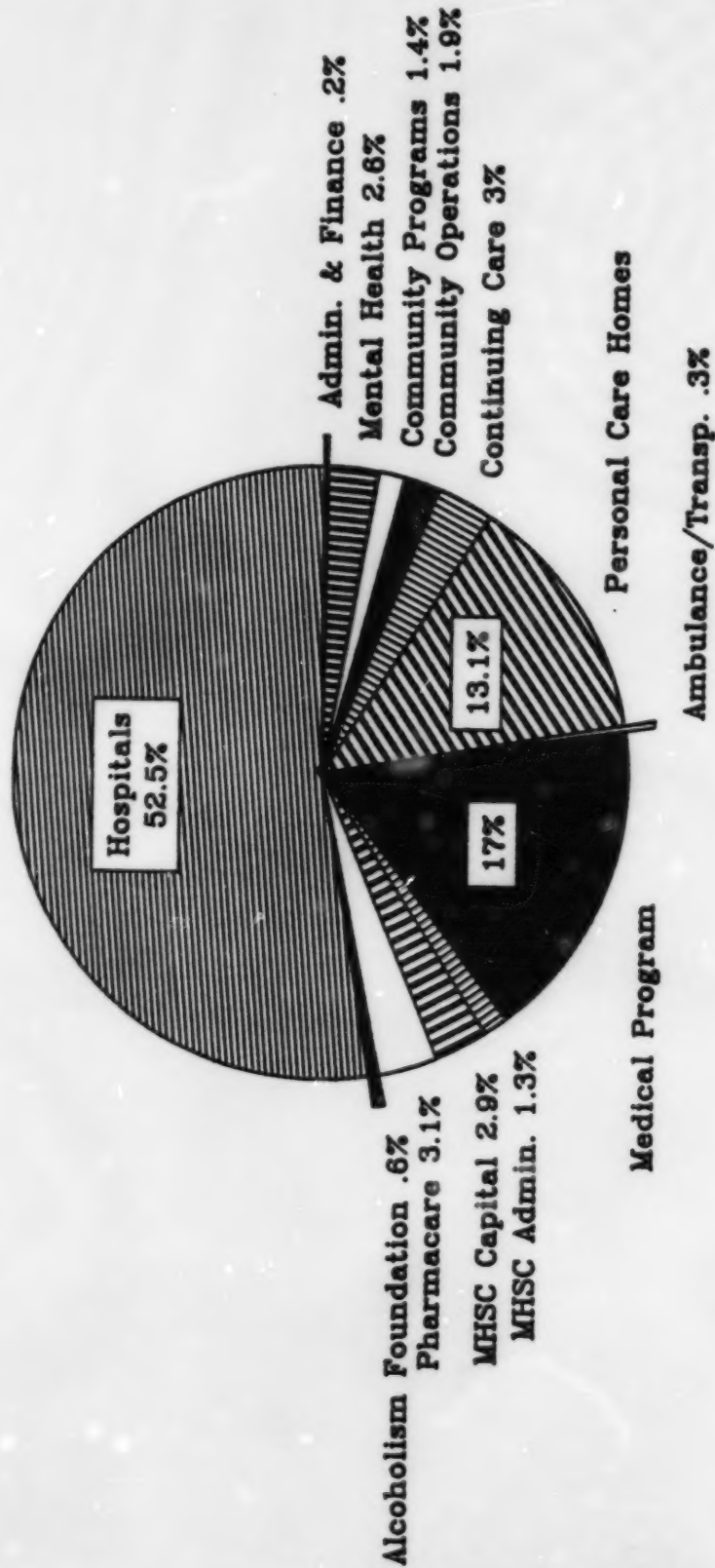


DIAGRAM 6

REFERRAL PROCESS - HOME CARE PROGRAM

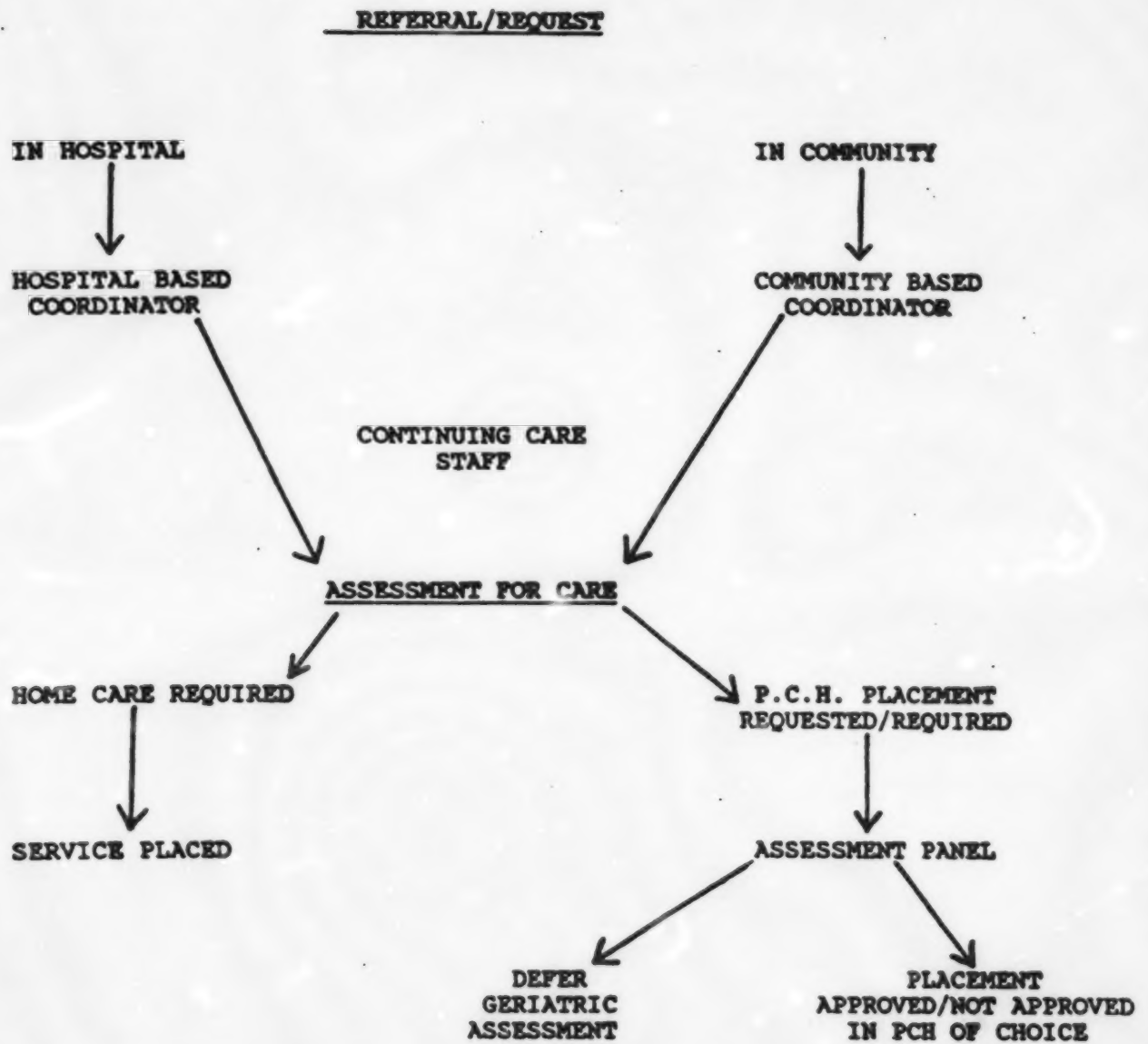
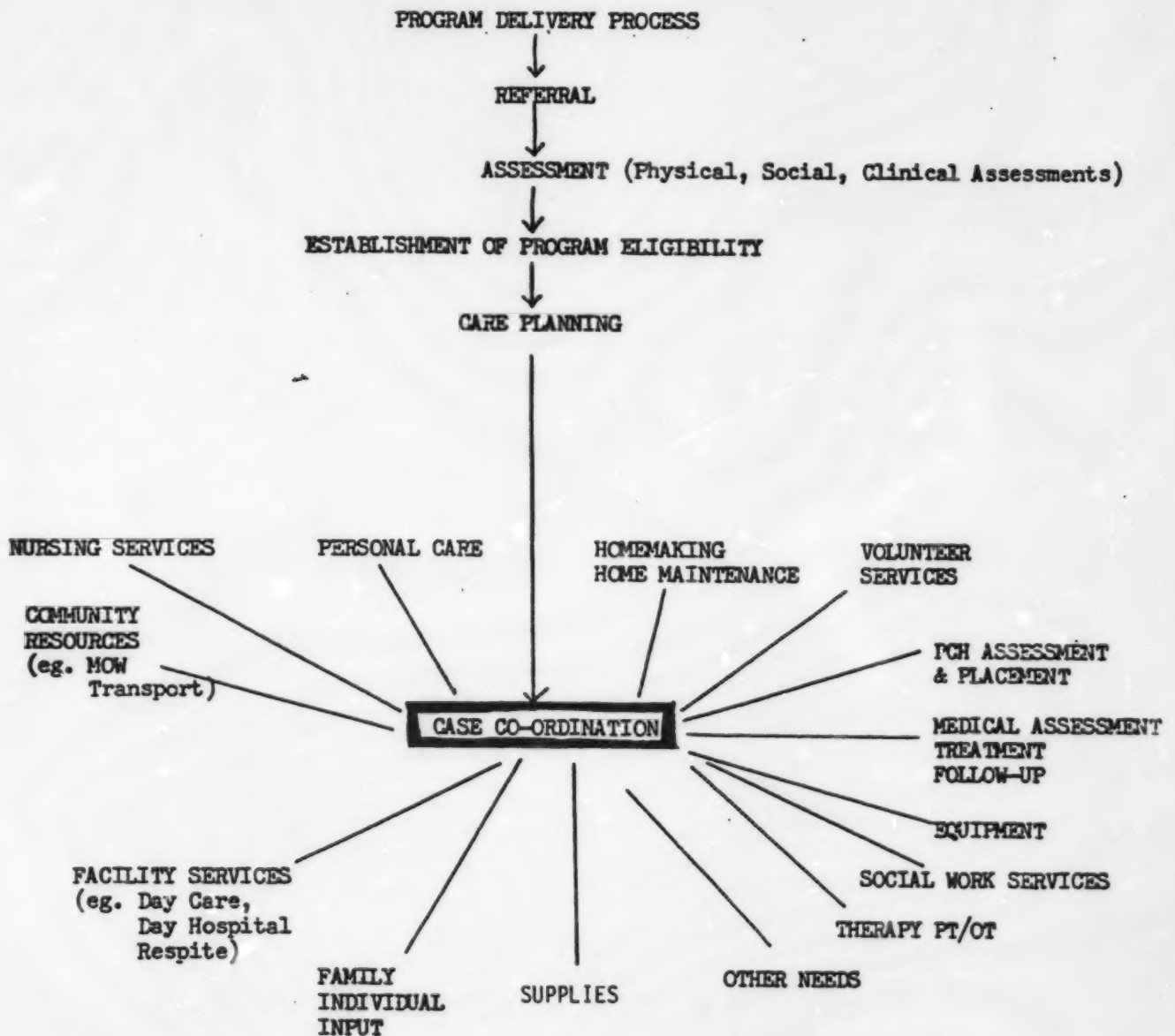


DIAGRAM 7



How the program is delivered at the field level.

**CONTINUING CARE PROGRAM
HOME CARE SERVICES**

<u>SERVICES</u>	<u>SERVICE PERSONNEL</u>
HEALTH CARE HEALTH TEACHING	REGISTERED NURSE or LICENSED PRACTICAL NURSE
HEALTH COUNSELLING SOCIAL COUNSELLING	CASE COORDINATOR (BACHELOR OF NURSING) CASE COORDINATOR (BACHELOR OF SOCIAL WORK)
HOUSEHOLD MAINTENANCE HOMEMAKING	HOME SUPPORT WORKER
PERSONAL CARE	REGISTERED NURSE LICENSED PRACTICAL NURSE HOME CARE ATTENDANT (INCLUDING ORDERLY)
FAMILY RELIEF	STAFF FROM ABOVE AS REQUIRED
RESPITE CARE	PERSONAL CARE HOME OR HOSPITAL
ADULT DAY CARE	PERSONAL CARE HOME, ELDERLY PERSONS HOUSING, OR OTHER
SUPPLIES AND EQUIPMENT	HOME CARE EQUIPMENT BRANCH
TRANSPORTATION; FRIENDLY VISITING, TELEPHONE ASSURANCE, SHOPPING	VOLUNTEERS

**MANITOBA
PROJECTED POPULATION 65+ AND PROJECTED % POPULATION 65+**

YEAR	65-69 %	70-74 %	75-79 %	80-84 %	85+ %	TOTAL
1991	45,100 30.3%	37,000 24.9%	30,600 20.6%	19,900 13.4%	16,200 10.9%	148,800
1996	41,800 26.6%	39,800 25.3%	31,300 19.9%	24,000 15.2%	20,500 13.0%	157,400
2001	40,100 24.8%	37,200 23.0%	34,100 21.0%	25,000 15.4%	25,600 15.8%	162,000
2006	41,700 24.9%	36,100 21.6%	32,400 19.4%	27,700 16.6%	29,300 17.5%	167,200
2011	50,200 27.8%	38,100 21.1%	31,800 17.6%	26,700 14.8%	33,500 18.6%	180,300

MANITOBA POPULATION 65+ JUNE 1, 1990

AGE GROUP	TOTAL PER AGE GROUP	MALE	FEMALE
65+	145,303	61,115	84,188
70+	99,416	40,398	59,018
85+	14,593	4,649	9,944
90+	4,948	1,357	3,591

Source: Manitoba Health Services Commission

MANITOBA POPULATION 65+

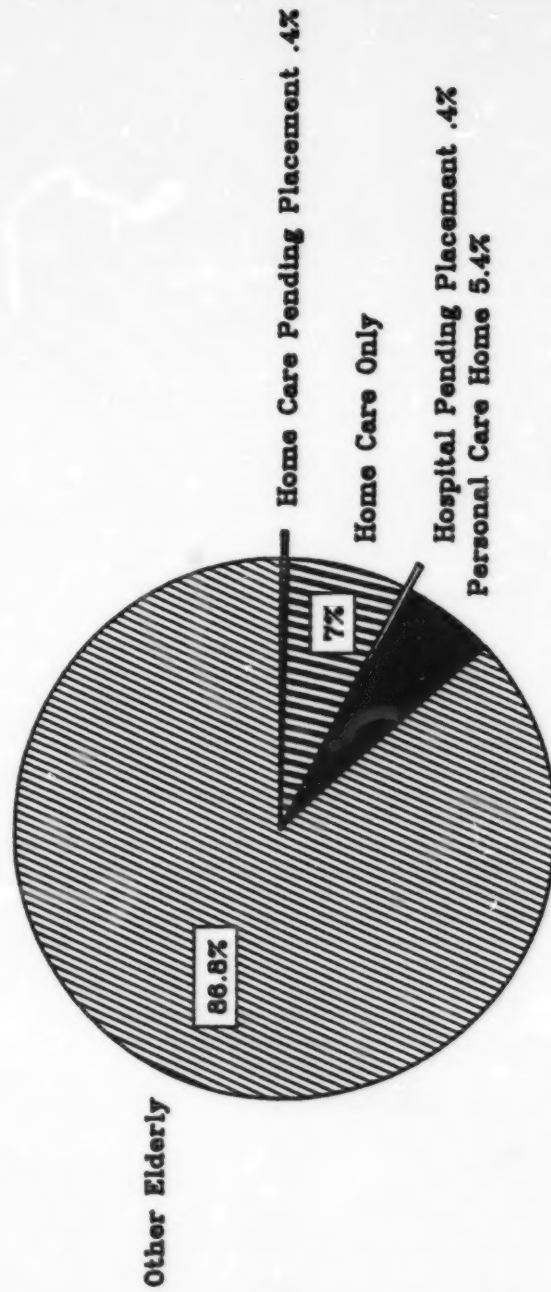


DIAGRAM 11

HOME CARE CASELOADS, TOTAL SERVED/1000 ELDERLY ¹ AND NURSING HOME BED SUPPLY ² 1984/85 TO 1990/91

	1984/85	1986/87	1988/89	1990/91
	-----	-----	-----	-----
In Program March 31	11,848	13,193	13,083	13,467
Admissions	10,438	11,827	10,320	10,555
Discharges	9,479	11,409	11,286	9,991
Total Served During Year	21,371	25,020	23,403	24,022
Total Served/1000 Elderly	165.1	173.4	166.7	165.3
P.C.H. Bed Supply/ 1000 persons aged 75+	159.9	149.7	143.8	136.1

1. Source: Office of Continuing Care, Manitoba Health
2. Source: Annual Reports, Manitoba Health Services Commission

DIAGRAM 12

CARE LEVEL EQUIVALENT OF PERSONS ADMITTED TO HOME CARE 1990/91

	<u>N</u>	<u>%</u>
Hospital	5,232	49.6%
Personal Care Home	3,642	34.5%
Neither	<u>1,681</u>	<u>15.9%</u>
Total	10,555	100.0%

Source: Office of Continuing Care, Manitoba Health

DIAGRAM 13

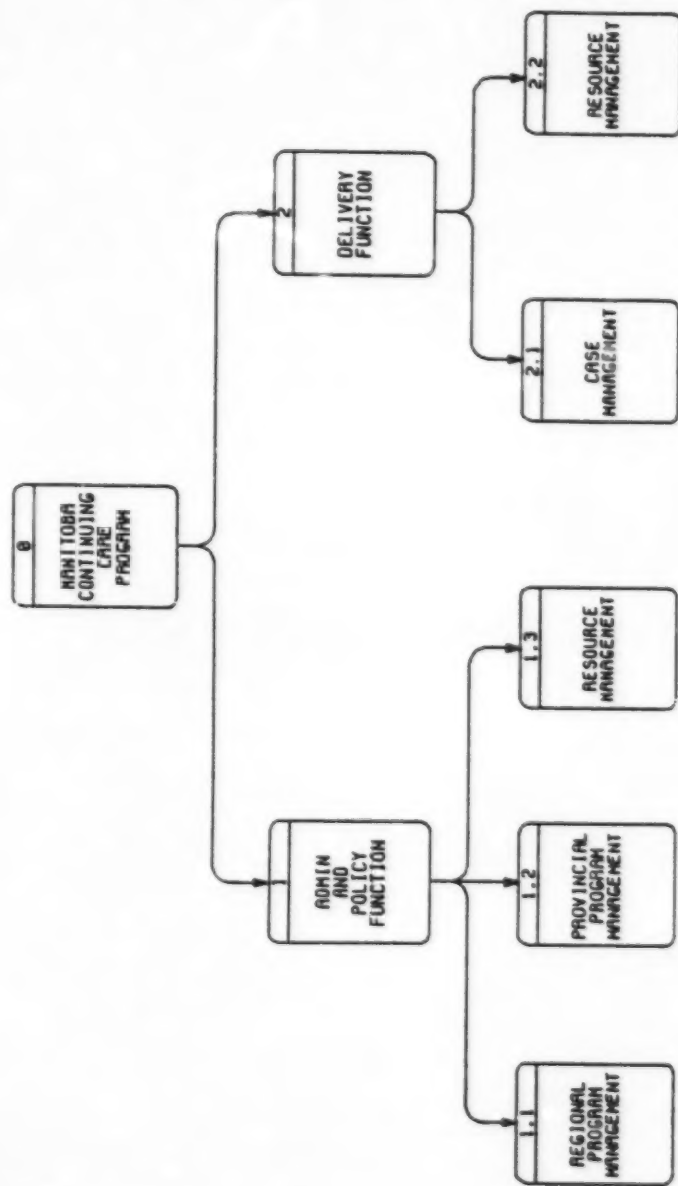
ANNUAL COST PER PERSON SERVED
PERSONAL CARE HOMES AND HOME CARE
1990/91

Personal Care Home	\$ 26,452.00 ¹
Home Care Services Only	\$ 2,118.51 ²
Home Care Services, plus Administration, Assessment, Case Coordination ³	\$ 2,595.33 ²

1. Source: 1990/91 Annual Report
Manitoba Health Services Commission
2. Source: Office of Continuing Care, Manitoba Health
3. Excludes cost for Administrative Services branch
area for Home Care Equipment and Supplies.

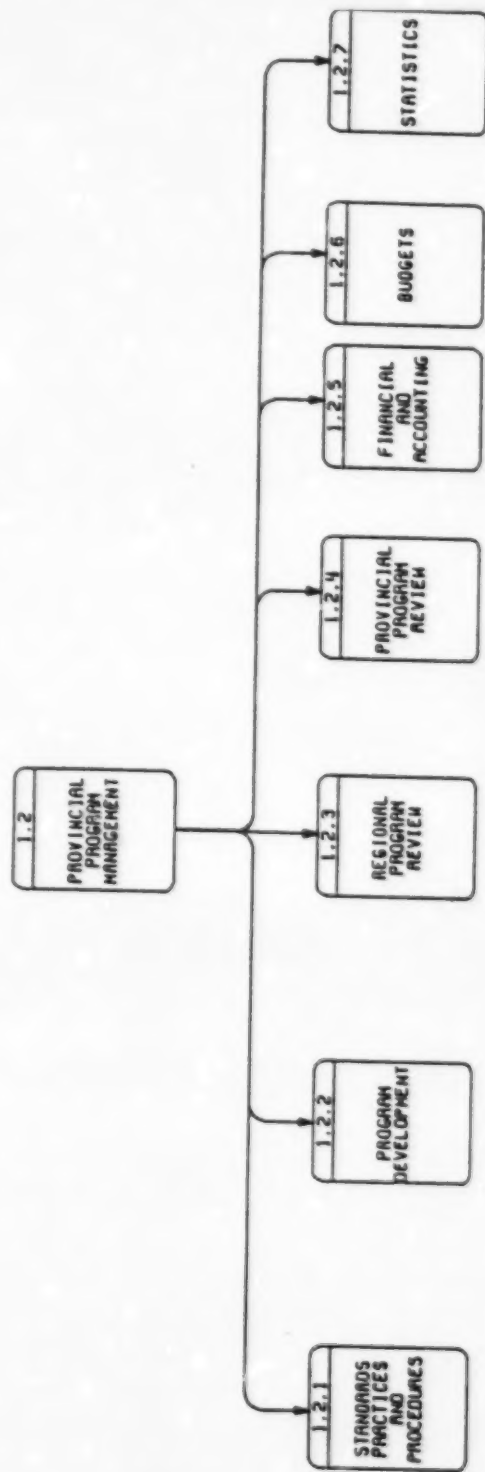
DIAGRAM 14

FUNCTIONAL MODEL OF THE MANITOBA CONTINUING CARE PROGRAM



Source: The Coopers & Lybrand Consulting Group, January 1990

1.2 PROVINCIAL PROGRAM MANAGEMENT



Source: The Coopers & Lybrand Consulting Group, January 1990

DIAGRAM 16

The Provinces of Canada



PROVINCE OF MANITOBA

POPULATION: 1,130,845 *
(June 1, 1990)

* Source: Manitoba Health Services Commission